

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

FOR: HEALTH CARE FINANCING ADMINISTRATION

**TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES**

1. TRANSMITTAL NUMBER:

02-19

2. STATE

NC

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE
SOCIAL SECURITY ACT (MEDICAID)

4. PROPOSED EFFECTIVE DATE

October 1, 2002

5. TYPE OF PLAN MATERIAL (*Check One*):

☐ NEW STATE PLAN

☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN

☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (*Separate Transmittal for each amendment*)

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR 447-201

7. FEDERAL BUDGET IMPACT:

a. FFY 03 (\$ 45,752)

b. FFY 04 (\$ 47,125)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-B, Section 23, Page 1

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (*If Applicable*):

Attachment 4.19-B, Section 23, Page 1

10. SUBJECT OF AMENDMENT:

Payments for Ambulance services

11. GOVERNOR'S REVIEW (*Check One*):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT

☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☒ OTHER, AS SPECIFIED: Not Required

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:

Carmen Hooker Odom

14. TITLE:

Secretary

15. DATE SUBMITTED:

December 23, 2002

16. RETURN TO:

Office of the Secretary
Department of Health and Human Services
2001 Mail Service Center
Raleigh, North Carolina 27699-2001

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

December 31, 2002

18. DATE APPROVED:

March 25, 2003

PLAN APPROVED ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

October 1, 2002

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

Ronda R. Catrell

22. TITLE:

Regional Administrator
Division of Maternal & Children's Health

23. REMARKS:

MEDICAL ASSISTANCE
State NORTH CAROLINA

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICE

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.
 - a. Transportation.
 1. **AMBULANCE-**
Payment to private providers will not exceed customary charges which are reasonable, based on prevailing rates in the State. Notwithstanding any other provision, if specified these rates will be adjusted as shown on Attachment 4.19-B, Supplement 2, Page 1 of the state plan. Interim payment to public providers will be set at the same level as private providers and will be cost settled to equal the cost of services provided during the fiscal period beginning July 1, 1999 through June 30, 2000, and for subsequent 12 month fiscal periods. Cost will be determined by the Division of Medical Assistance by review of an annual cost finding in accordance with OMB Circular A-87 and the HCFA-15 Provider Reimbursement Manual. A statewide average cost for each type of transport will be developed and compared to the interim payment, based on this comparison, additional payment or recovery of payment will be made to assure that the total of payment equals cost.
 2. **MEDICALLY NECESSARY TRANSPORTATION OTHER THAN AMBULANCE-**
 - (a) Unless ambulance transportation is needed as described in Rule 10 NCAC 26B .0110, County Departments of Social Services are responsible for providing medically necessary transportation: except, for clients who are residents of medical facilities and non-medical facilities. Medical facilities and non-medical facilities are responsible for medically necessary transportation for residents.
 - (b) Payments for medically necessary transportation shall be made in accordance with the provisions of 42 C.F.R. 434.12, which is incorporated by reference with subsequent changes and amendments. A copy of 42 C.F.R. 434.12 can be obtained from the Division of Medical Assistance at a cost of twenty cents (0.20) a copy.
 3. **CONTRACTS WITH PRIVATE NON-MEDICAL INPATIENT INSTITUTIONS-**
The Division of Medical Assistance will enter into contracts using 42 CFR 434-12 for the provision of medically related patient transportation to and from other health care providers for State/County Special Assistance clients residing in domiciliary care homes.
Reimbursement is determined by the Division of Medical Assistance based on a capitation per diem fee derived from industry transportation cost with annual inflation adjustment. The rate may be recalculated from a cost reporting period selected by the state.